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DEPARTMENT OF HE/ _TH AND HUMAN SERVICES
CENTERS FOR MEDIC ARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G167	A. BUILDING _____ B. WING _____	08/21/2008

NAME OF PROVIDER OR SUPP IER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 10	1613 TAYLOR STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMAF / STATEMENT OF DEFICIENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATOR' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR IATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMI IENTS A recertificatic n survey was conducted from August 18, 20)8, through August 21, 2008. The survey was in iated using the full survey process. A random sar ple of three clients was selected from a reside tial population of four women and two men with nental retardation and other disabilities. T ie findings of the survey were based on obs rvations, interviews at the facility and at three c ay programs, and a review of records, inclu ling unusual incident reports.	W 000	Received 9/29/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility m ist ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavio al status, attendant risks of treatment, an l of the right to refuse treatment. This STAND/ RD is not met as evidenced by: Based on ob: ervation, interview and record review, the fa cility failed to ensure the rights of each client a d/or their legal guardian to be informed of t e client's medical condition, development l and behavioral status, attendant risks of treat ient, and the right to refuse treatment, fo one of the three clients (Client #2) included in th e sample. The finding ir cludes: The facility fa led to provide evidence that informed cor sent was obtained from Client #2 and/or her le al guardian for her psychotropic medications ind Behavior Support Plan (BSP).	W 124	The QMRP will ensure that informed consent is obtained from the client and/or decision maker for psychotropic medications and behavior support plans.	10/21/8

LABORATORY DIRECTOR'S OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Marsha H. Thompson Director of Disability Services 9/29/08

Any deficiency statement end ig with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providin ; it is determined that other safeguards provide suffi ient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above a e disclosable 90 days following the date of survey w ether or not a plan of correction is provided. For nursing homes, the above findings and plans of correct on are disclosable 14 days following the date these ocuments are made available to the facility. If deficiencies are cited, an approved plan of correction is r quisite to continued program participation.

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W 124	Continued Fr m page 1 Observation f the evening medication administratio on August 19, 2008 at 5:09 PM revealed Clie t #2 received medication including Benztropine mg. Interview with the medication nurse during he medication administration revealed the fo rementioned medications were used to addr ss the client's behaviors. Interview wit th e Qualified Mental Retardation Professional QMRP) on August 19, 2008, at 11:36 AM re ealed that Client #2 did not have the capacity to gi e informed consent for the use of medications nd habilitation services. The QMRP's stat ment was verified on August 21, 2008, at 10:1 AM through review of Client #2's psychologica assessment dated August 9, 2008. According to he assessment, Client #2 "is not able to make independent decisions concerning her treatmen plan; financial affairs, living arrangement cr day placement. She lacks the cognitive anc academic skills necessary to understand t e implications of such decision, and therefore car ct give her informed consent in regards to th se matters. She likewise cannot execute a du able of power of attorney." Review of Cl ent #2's medical record on August 20, 2008 at 3 48 PM revealed a written physician's o der dated July 2008, that documented he client was also prescribed Abilify 10 mg each morning. Interview with the QMRP during the er rance conference on August 19, 2008, reveal d Client #2 did not have a guardian, but a hearing to obtain a legal guardian was pending. The QMRP r vealed that the facility had attempted to contact the client's family, but were	W 124		

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W 124	Continued Fr m page 2 unsuccessful Record verification on August 21, 2008, at 10:1 AM revealed a generalized letter sent to Client #2's family dated October 5, 2007. Further revie of the letter revealed that the client's family was being notified that the "resident must have or file signed consent forms which must be upda ted annually or whenever there is a change in me dication or dosage." Additionally, continued rev ew of the letter revealed a consent form attache to the letter identifying the prescribed ps chotropic medication (Abilify 10 mg once daily) a d a copy of client #2's BSP. At the time of the su vey, the facility failed to provide evidence tha informed consent was obtained from the clier and/or legally authorized representativ for the psychotropic medications and her BSP	W 124		
W 126	483.420(a)(4 PROTECTION OF CLIENTS RIGHTS The facility m st ensure the rights of all clients. Therefore, th facility must allow individual clients to manage th ir financial affairs and teach them to do so to th extent of their capabilities. This STAND RD is not met as evidenced by: Based on int rview and record review, the facility failed to ensu e clients were being taught to manage thei finances to the best of their abilities, for one of the three clients (Client #3) included in the sample. The findings nclude: Interview witl the Qualified Mental Retardation Professional QMRP) on August 19, 2008, at 11:36 AM re ealed that Client #3 was not capable of managing his finances. Further interview with	W 126	The QMRP will assess the clients' ability to manage their own finances and will ensur e that appropriate training programs to improve heir skill levels are developed and implemented.	10/21/08

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W 126	Continued Fro n page 3 the QMRP on August 21, 2008 at 1:59 PM revealed the f cility was responsible for managing the client's fin nces in collaboration with the Department o Disability Services (DDS). The QMRP additic ally revealed the client received Supplemental Security Income (SSI) in the amount of $1(0.00 monthly. Review of the client's bank s tatements on August 21, 2008 at 4:05 PM verif ed the monthly SSI. On August 21 2008, at 4:05 PM the client's money mana ement skills assessment was reviewed and revealed the following skill needs: - Dependent n identifying the type and number of coins need ed to make a purchase from a vending mac ine. - Dependent n budgeting available money. Additional int rview with the QMRP and further review of the assessment revealed that although the client wa capable of carrying cash ($1.00), there was no evidence that the client had been assessed to determine his understanding of the complete val e of the money ($1.00). There was no evidence Client #3 was assessed to determine his understa ding of coin denominations and/or combinations . Furthermore, at the time of the survey, the f cility failed to provide evidence that Client #3 wa being provided with money managemen training to increase his skills in that domain.	W 126		
W 130	483.420(a)(7 PROTECTION OF CLIENTS RIGHTS The facility n ust ensure the rights of all clients. Therefore, th e facility must ensure privacy during treatment ar l care of personal needs.	W 130	The QMRP will retrain staff on clients' ri ht to privacy.	10/21/08

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W 130	Continued Fro	n page 4	W 130		
	This STANDA	RD is not met as evidenced by: Based on obs rvation and interview, the facility failed to ensu e each client's right to privacy, for one of the thr e clients (Client #1) included in the sample. The finding in ludes: Observation c n August 19, 2008, at 4:08 PM revealed the c irect care staff escorting Client #1 to the facility's bathroom. The staff was observed to assist the c ient to sit on the toilet with the bathroom doc opened. The staff stood in the doorway of th bathroom with the door opened, while Client # sat on the toilet. The facility failed to ensure Clie nt #1 was provided privacy.			
W 137	483.420(a)(1	) PROTECTION OF CLIENTS RIGHTS The facility m is: ensure the rights of all clients. Therefore, th facility must ensure that clients have the righ to retain and use appropriate personal pos essions and clothing.	W 137	The QMRP will retrain staff to assist clien s to choose appropriate clothing.	10/21/08
	This STAND	RD is not met as evidenced by: Based on ob: ervation and interview, the facility failed to ensu e the right of each client to retain the use of ad equate clothing, for one of the three clients (Clien #1) included in the sample. The finding i cludes: Observation of Client #1 on August 19, 2008, at 5:19 PM reve aled the client walking to the living room. It sho ld be noted that the client had just arrived to the facility from her day program. She			

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W 137	Continued From page 5 was observed wearing a pair of sheer pink pants that exposed her undergarments. Interview was conducted with the direct care staff on the aforementioned date revealed the overnight shift was responsible for assisting Client #2 with selecting her clothes. At the time of the survey, the facility failed to ensure the client wore adequate clothing that did not expose the client's undergarments.	W 137		
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on interview and the record review, the facility failed to provide evidence that assured a system had been established that maintained a complete accounting of each clients' personal funds, for one of the three clients (Client #3) included in the sample. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on August 19, 2008, at 11:36 AM revealed that Client #3 was not capable of managing his finances. Further interview with the QMRP on August 21, 2008, at 1:59 PM revealed the facility was responsible for managing the client's finances in collaboration with the Department of Disability Services (DDS). The QMRP additionally revealed the client received Supplemental Security Income (SSI) in the amount of $[illegible]00.00 monthly.	W 140	The QMRP will maintain receipts and other proofs that justify the client's expenditures from his community account.	10/21/08

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W 140	Continued From page 6 Continued interview with the QMRP and review of the facility's financial records on August 21, 2008, at 4:05 PM revealed $114.56 was withdrawn from the client's account on February 7, 2008. The QMRP was interviewed regarding the aforementioned withdrawal and at the time of the survey, failed to provide evidence that justified the withdrawal/expenditure from Client #3's personal account.	W 140		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure parents/guardians were notified of serious incidents, one of the three clients (Client #1) included in the sample. The finding includes: Review of the facility's incident reports on August 19, 2008, beginning at 9:50 AM revealed the following: On October 5, 2008 a direct care staff discovered a bruise on Client #1's lower lip. According to her report, the client was unable to explain or tell what happened. Interview with the QMRP during the entrance conference on August 19, 2008, at 11:36 AM	W 148	The Director of Disability Services will review incident policy implementation with the QMRP and home staff to ensure that they provide appropriate, timely notice of incidents to family members and others, and that investigations are completed and filed appropriately.	10/21/08

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W 148	Continued From page 7 revealed Client #1 had a sister that was involved in her care. At the time of the survey, however, the facility failed to provide evidence that Client #1's sister had been notified of the aforementioned incident.	W 148		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to implement policies that ensured the client's health and safety, for one of the three clients (Client #1) included in the sample. The finding includes: The facility failed to implement their Incident Management Policy (IMP) as evidenced below: Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the facility's incidents reports on August 19, 2008, beginning at 1:11 PM revealed an incident report involving Client #1. Continued review of the incident revealed that on October 15, 2007, staff reported observing a "bruise" on the client's lower lip. Additionally, another incident dated November 15, 2007, revealed the staff discovered a month later that the Client #1 had another "swollen lip." According to the review of the incident dated November 15, 2007, the client was taken to a local emergency room where she was diagnosed with "lip contusion with edema." Both of the aforementioned incidents failed to	W 149	See response to W148.	10/21/08

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W 149	Continued From page 8 provide evidence that they had been investigated. Interview with the QMRP on August 19, 2008, at 3:09 PM revealed that the facility's Incident Management protocol requires the staff to fax the incident reports within twenty-four hours to their Incident Management Coordinator (IMC). Further interview with the QMRP revealed if the incident was regarded as a "serious reportable" incident the IMC would conduct an investigation. Review of the facility's Incident Management Policy and Procedure on August 20, 2008, revealed "all incidents will be investigated by [Provider] within 12 hours after the incident was witnessed, discovered or being informed that the incident has occurred." At the time of the survey, the facility failed to provide evidence that injuries of unknown origin was investigated.	W 149		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all injuries of unknown origin were thoroughly investigated, for one of the three clients (Clients #1) included in the sample. The findings include : Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the facility's incidents reports on August 19, 2008,	W 154	See response to W 148.	10/21/08

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W 154	Continued From page 9 beginning at 9:50 AM revealed the following: a. On October 15, 2007, staff reported observing a "bruise" on [Client #1's] lower lip. Further interview with the QMRP on August 19, 2008, revealed that she was not certain if the incident reported on October 15, 2008, had been investigated. b. On November 15, 2007, staff discovered Client #1's "lip was swollen." The client was taken to a local emergency room where she was diagnosed with "lip contusion with edema." According to the QMRP the incident reported on November 15, 2008, had not been investigated. At the time of the survey, the facility failed to provide evidence that the aforementioned incidents had been investigated.	W 154		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure required investigations were reviewed by the administrator or designee within five working days, for one of the six clients (Client #5) that resided in the facility. The findings include: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the facility's	W 156	See response to W148.	10/21/08

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W 156	Continued From page 10 incidents reports and corresponding investigation reports on August 19, 2008, at 1:01 PM revealed the following: On October 2., 2007, staff reported discovering Client #5 with a bruise on her right shoulder and chest. According to the report, the client revealed that she fell. Review of the corresponding incident summary report investigation dated October 25, 2007, revealed the client indicated she "fell out bick with another staff." The staff member referred to was the client's one to one support staff. Continued review of the incident summary report investigation revealed that staff were interviewed and no staff could substatiate the client's claim of falling or any such occurence that would have caused the client's injury. Further review of the summary report documented that Client #5 revealed the cause of the injury occurred from allegedly being removed off of the van. It was later determined, after Client #5 was seen by her primary care physician, that the injuries were consistent with that of "rug burns." The final results of the investigation revealed that the injuries were potentially caused by a mastabatory incident. Additional review of the incident summary report investigation dated October 25, 2007 revealed the report was completed by the Qualified Mental Retardation Professional (QMRP). Interview with the QMRP on August 19, 2008 beginning at 3:09 PM revealed the administrator was responsible for reviewing incident investigations within five days. At the time of the survey, the facility failed to provide evidence that the results of the aforementioned investigations were reviewed as	W 156		

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W 156	Continued From page 11 required.	W 156		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP). The findings include: 1. The QMRP failed to ensure Client #3 received a re-evaluation from the Speech Pathologist. Observation of Client #3 on August 19, 2008 at 2:53 PM revealed the client plugging in his communication device after returning home from the day program. Interview with a staff member at 4:00 PM revealed that the client used the communication device to indicate he wanted a shave. Review of Client #3's habilitation records on August 20, 2008, at 4:25 PM revealed the client had an Individual Support Plan (ISP) and corresponding Individual Program Plans (IPP) dated April 2, 2008. Further review of Client #3's IPP's revealed the client had a program that required him to use his communication device to answer a simple question. Interview with the Qualified Mental Retardation Professional (QMRP) and additional review of Client #3's	W 159	1. The QMRP will ensure that the Speech Language Therapist evaluates the client's training needs on the communication device, and provides recommendations, instruction, and technical assistance as required in order to implement such training.	10/21/08

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	09G167	A. BUILDING _____ B. WING _____	08/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 10	1613 TAYLOR STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 12 record (QMRP Monthly Notes) on August 20, 2008 at 5:20 PM revealed the client had achieved the aforementioned program in May 2008. Review of the June 2008 QMRP monthly note on August 20, 2008 revealed documentation that indicated that Client #3's usage of the communication device was to be re-evaluated by the Speech Pathologist to "determine the best training technique" for him. Continued interview was conducted with the QMRP to ascertain if the re-evaluation had been conducted. At the time of the survey, the facility failed to provide evidence that the Speech re-evaluation had been conducted. It should be additionally noted that the facility failed to provide evidence of any comprehensive Speech evaluation/assessment for Client #3. 2. The QMRP failed to ensure each client received continuous active treatment services. (See W249) 3. The QMRP failed to ensure that data was collected in the form and frequency required. (See W252) 4. The QMRP failed to ensure an exercise video was secured for Client #1. Observation on Client #1 on August 19, 2008, at 4:49 PM revealed the client on the floor in the living room performing floor exercises with staff (stretches and sit-ups). The client was observed to perform the exercises independently with verbal prompts from the staff. Review of Client #1's habilitation records on August 21, 2008, at 1:39 PM revealed the client	W 159	2. See response to W249. 3. See response to W252. 4. The QMRP will obtain the exercise video for the client.	10/21/08 10/21/08 10/21/08

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W 159	Continued From page 13 had an Individual Support Plan (ISP) and corresponding Individual Program Plans (IPP) dated April 2?, 2008. Further review of Client #1's IPP's revealed the client had a program that required her to use an exercise video to participate in exercises. Review of Client #1's available QMRP monthly notes for April 2008 to June 2008 or August 21, 2008, at 3:04 PM documented that video had not been secured. The QMRP was interviewed on August 21, 2008, at 3:09 PM to ascertain if the client had the specified video. The QMRP revealed the video had not been obtained. At the time of the survey, the facility failed to Client #1 was provided with the necessary video to complete her aforementioned exercise program.	W 159		
W 249	483.440(d)(1 PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure each client received continuous active treatment services, including needed interventions for one of the three clients (Client #2) included in the sample. The findings include: Review of Client #2's habilitation record on	W 249	Henceforth the QMRP will ensure that as soon as the IDT accepts recommendations for active treatment, programming will be formulated and implemented.	10/21/08

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W 249	Continued Fr m page 14 August 21, 2(08, at 12:05 PM revealed an Individual Su port Plan (ISP) dated August 15, 2008. Furth r review of the client's record revealed that at the time of the ISP meeting, the interdiscipline y team recommended a program objective for he client to independently get a cup of water to ta e her medication on 75% of trials per month fo three months. Another prog ram objective recommended was that Client #2 would prepare her lunch with verbal prompts on a l sessions per month for three months, fives times a week. Continued re iew of the record revealed the Speech Ther ip st assessed Client #2 on June 25, 2008, and re ommended that the client be encouraged t o use signing in as many communicati n situations as possible. Additionally, he Speech Therapist also made a recommenda ion for the client to be encouraged to use audito y as well as sign language when engaging her in ADL activities. Client #2 was also assessed by he Physical Therapist on August 7, 2008. The P ysical Therapist recommended that the client be engaged in physical activity, ball play, dancing and walking at a faster pace to increase her energy expenditure." Review of Cl ent #2's program record revealed that the afore mentioned recommendations had not been imp emented. Interview wit the Qualified Mental Retardation Professional (QMRP) was conducted on August 21, 2008, at :59 PM. The QMRP verified that the program objectives had not been implemented but that they would be implemented on the day o the survey (August 21, 2008). At the time o the survey, the facility failed to	W 249		

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W 249	Continued Fr m page 15 ensure Client #2's new program objectives were implemented imely as required.	W 249		
W 252	483.440(e)(1 PROGRAM DOCUMENTATION Data relative o accomplishment of the criteria specified in c ent individual program plan objectives mu st be documented in measurable terms. This STAND ARD is not met as evidenced by: Based on obs ervation, interview and record review, the fa cility failed to ensure data relative to the accompli hment of the criteria specified in each client's ndividual Program Plan (IPP) objective was documented in measurable terms, for one of the three clients (Client #3) included in the sample. The findings nclude: 1. Observati n of Client #3 on August 19, 2008 at 2:53 PM re vealed the client plugging in his communicati n device after returning home from the day progr am. Interview with a staff member at 4:00 PM re vealed that the client used the communicati n device to indicate he wanted a shave. Review of Cli ent #3's habilitation records on August 20, 2 08, at 4:25 PM revealed the client had an Indivi ual Support Plan (FISP) and correspondin g Individual Program Plans (IPP) dated April 2 , 2008. Further review of Client #3's IPP's re ealed the client had a program that required him o shave his face three times per week with ve bal prompts. Review of the correspondin g data collection record on August	W 252	1. The QMRP will ensure that data collect on is monitored at least weekly, and will retrain staff on the requirement to collect data.	10/21/08

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W 252	Continued From page 16 20, 2008 however, failed to provide evidence that data was being collected on the aforementioned program. Interview with the Qualified Mental Retardation Professional (QMRP) and additional review of Client #3's record (QMRP Monthly Notes date July 10, 2008 on August 20, 2008 at 5:20 PM revealed that there was no data for the shaving program for the months of May 2008 and June 2008. The QMRP was further queried to ascertain if the program was being implemented and she indicated that the program was being conducted. At the time of the survey, however, there was no documented evidence that the program was being conducted and data was being collected. 2. Observation on August 19, 2008, at 5:13 PM revealed the direct care staff assisting Client #2 in the kitchen. The staff verbally prompted the client to select one of the cups from the countertop. The client was observed to select and pick up one of the cups independently. Client #2 was observed to turn on the water independently and filled her cup. The client was observed to pour the water in the sink. The staff would encourage the client to hold the cup of water, but she would continuously fill the cup with water and pour it out in the sink. The client refused to hold the cup of water until it was time for her to receive her medication. Review of Client #2's habilitation record on August 21, 2008, at 12:05 PM revealed an Individual Support Plan (ISP) dated August 15, 2008. Further review of the client's record revealed that at the time of the ISP meeting, the interdisciplinary team recommended a program	W 252	2. See response to W249 and W252 #1.	10/21/08

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W 252	Continued From page 17 objective for the client to independently get a cup of water to take her medication on 75% of trials per month for three months. Another program objective recommended was that Client #2 would prepare her lunch with verbal prompts on all sessions per month for three months, five times a week. Continued review of the record revealed the Speech Therapist assessed Client #2 on June 25, 2008, and recommended that the client be encouraged to use signing in as many communication situations as possible. Additionally, the Speech Therapist also made a recommendation for the client to be encouraged to use auditory as well as sign language when engaging her in ADL activities. Client #2 was also assessed by the Physical Therapist on August 7, 2008. The Physical Therapist recommended that the client be engaged in physical activity, ball play, dancing and walking at a faster pace to increase her energy expenditure." Interview with the Qualified Mental Retardation Professional (QMRP) was conducted on August 21, 2008, at :59 PM. The QMRP verified that the program objectives had not been implemented but that they would be implemented on the day of the survey (August 21, 2008). At the time of the survey, there was no documented evidence that the program was being conducted and data was being collected.	W 252		
W 263	483.440(f)(3) ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a	W 263	See response to W124.	10/21/08

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W 263	Continued From page 18 minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's Human Rights Committee (HRC) failed to ensure written informed consent had been obtained from the client and/or their legal guardian for the use of behavior support plans, for one of the three clients (Client #2) included in the sample. The finding includes: Observation of the evening medication administration on August 19, 2008, at 5:09 PM revealed Client #2 received medication including Benztropine mg. Interview with the medication nurse during the medication administration revealed the aforementioned medications were used to address the client's behaviors. There was no evidence that written informed consents were obtained to use the above behavior medication as part of a behavior management program.	W 263		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure evacuation drills were held quarterly on all shifts. The finding includes: Interview with the Qualified Mental Retardation	W 440	The QMRP will ensure that evacuation drills are held for each shift at least quarterly.	10/21/08

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W 440	Continued F om page 19 Professional QMRP) on August 19, 2008 at 2:45 PM revealed the direct care staff were assigned the following shifts of duty: Weekdays a d Weekends 7:00 AM - 3: 0 PM 3:00 PM - 11 00 PM 11:00 PM - 7 00 AM Review of th evacuation drill records on August 19, 2008 at 2 :47 PM revealed the last evacuation drill for the m orning shift (7:00 AM - 3:00 PM) was held on Augu st 17, 2007 at 7:30 AM. Continued review of the evacuation drill records revealed the last evacuati n drill for the evening shift (3:00 PM - 11:00 PM) as held on February 19, 2008 at 6:00 PM. Fu ther interview was conducted with the QMRP th at verified the aforementioned information a nd revealed that there were no other evacuation d ill records. At the time of the survey, the fa ci ity failed to provide evidence that evacuation d ills were conducted quarterly for each shift of personnel.	W 440		
W 448	483.470(i)(2) iv) EVACUATION DRILLS The facility n ust investigate all problems with evacuation d ills, including accidents. This STAND RD is not met as evidenced by: Based on int rview and record review, the facility failed provid evidence that ensured problems with evacuat on drills were investigated and addressed. The finding i cludes: Review of th evacuation drill records on August 19, 2008 at 2 47 PM revealed the design of the	W 448	The QMRP will review and sign drill records per policy, and when a Residential Director is hired for the facility, the QMRP will ensure that sh /he is trained to manage the evacuation drill, and review the drill records. The QMRP will ensure that incidents, accidents, or needed repairs arise during the evacuation drills, they are investigated and addressed.	10/21/08

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W 448	Continued From page 20 evacuation drill records included a place for the signature of the person that completed the drill and required the signature of the person that reviewed the drill record. Continued review of the evacuation drills (from August 2007 through August 2008 failed to provide evidence that the drills records were reviewed. The Qualified Mental Retardation Professional (QMRP) was interviewed on August 19, 2008 to ascertain information regarding the person responsible for reviewing the evacuation drill records. The QMRP revealed that it was the role of the House Manager (HM) to review the records, but since the facility currently had no HM, the QMRP would be the responsible person. It should be noted that there was no evidence the evacuation drill records were reviewed for August 2007 through August 2008 Further review of the records revealed an evacuation drill dated November 19, 2007. According to the drill record, the staff documented that one of the lights was inoperable. Interview was conducted with the QMRP to ascertain if the light was repaired. The QMRP revealed that based on what was documented on the drill record, she was unaware of what light was in need or repair. When further queried to ascertain if the problem had been investigated the QMRP failed to be able to provide information and/or evidence that the issue had been addressed. At the time of the survey, the facility failed to provide evidence that problems associated with evacuation drills were addressed.	W 448		

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I 000	INITIAL COMMENTS A relicensure survey was conducted from August 19, 2008, through August 21, 2008. A random sample of three residents was selected from a residential population of four females and two males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at three day programs, interviews, and a review of records, including unusual incident reports.	I 000	Received 9/29/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to maintain the the facility in a clean, orderly, and attractive manner. The findings include: On August 2 , 2008, interview with the Qualified Mental Retardation Professional and observation of the the environment beginning at 4:18 PM revealed the following: 1. The picnic table located in the backyard was observed to have a broken plank on the top of the table. The table also had an inoperable microwave oven resting on top of it. 2. There were three garbage cans observed at the top of the stairs in the backyard that were not covered. One can was observed to have a large	I 090	1. The QMRP will have the picnic table repaired or removed. The QMRP will have the micro wave oven removed. 2. The QMRP will ensure that trashcans are in good repair, and are covered with appropriate lids.	10/21/08 10/21/08

Health Regulation Administration

Marsha M. Simpson — Director of Disability Svcs — 9/29/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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I 090	Continued Fr m page 1 hole located t the top of the can. 3. There wa a brick protruding from above the exterior rear xit doorway. 4. There wer one inoperable television on the floor in the ba sement in the activity room.	I 090	3. The QMRP will ensure that the brick is removed or properly set in place. 4. The inoperable TV will be repaired or d sposed.	10/21/08 10/21/08
I 189	3508.7 ADMI NISTRATIVE SUPPORT Each GHMR ' shall maintain records of residents ' funds recei ed and disbursed. This Statute s not met as evidenced by: Based on int rview and the record review, the facility failed o provide evidence that assured a system had b een established that maintained a complete acc ounting of each resident's personal funds, for on of the three residents (Resident #3) included n the sample. The finding i cludes: Interview witl the Qualified Mental Retardation Professional QMRP) on August 19, 2008, at 11:36 AM re ealed that Resident #3 was not capable of m naging his finances. Further interview witl the QMRP on August 21, 2008, at 1:59 PM reve aled the facility was responsible for managing th resident's finances in collaboration with the Dep rtment of Disability Services (DDS). The QMRP a dditionally revealed the client received Sup plemental Security Income (SSI) in the amount o $100.00 monthly. Continued in erview with the QMRP and review of the facility's f nancial records on August 21, 2008, at 4:05 PM re vealed $114.56 was withdrawn from the resident's account on February 7, 2008. The QMRP was i terviewed regarding the	I 189	See response to federal deficiency W126.	10/21/08

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I 189	Continued F om page 2 aforementior ec withdrawal and at the time of the survey, failec tc provide evidence that justified the withdraw l/expenditure from Resident #3's personal acc ount.	I 189		
I 422	3521.3 HABI ITATION AND TRAINING Each GHMR shall provide habilitation, training and assistan e to residents in accordance with the resident s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on int rview and record review, the GHMRP faile d to ensure habilitation, training and assistance w as provided to its residents in accordance with their Individual Habilitation Plan(s), for c ne of the three Residents (Resident #2) included n the sample. The finding i cludes: Review of Re sident #2's habilitation record on August 21, 2 008, at 12:05 PM revealed an Individual Su pport Plan (ISP) dated August 15, 2008. Furth r review of the Resident's record revealed tha at the time of the ISP meeting, the interdisciplin ry team recommended a program objective for he resident to independently get a cup of water o take her medication on 75% of trials per mo th for three months. Another program obj ctive recommended was that Resident #2 would prepare her lunch with verbal prompts on a l sessions per month for three months, five times a week. Continued re iew of the record revealed the Speech Ther apist assessed Resident #2 on June 25, 2008, an recommended that the Resident be encouraged o use signing in as many communicati n situations as possible.	I 422	See response to federal deficiency W252	10/21/08

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 422	Continued From page 3 Additionally, the Speech Therapist also made a recommendation for the resident to be encouraged to use auditory as well as sign language when engaging her in ADL activities. Resident #2 was also assessed by the Physical Therapist on August 7, 2008. The Physical Therapist recommended that the Resident be "engaged in physical activity, ball play, dancing, and walking at a faster pace to increase her energy expenditure." Review of Resident #2's program record revealed that the aforementioned recommendations had not been implemented. Interview with the Qualified Mental Retardation Professional (QMRP) was conducted on August 21, 2008, at 2:59 PM. The QMRP verified that the program objectives had not been implemented but that they would be implemented on the day of the survey (August 21, 2008). At the time of the survey, the GHMRP failed to ensure Resident #2's new program objectives were implemented timely as required.	I 422		

PRINTED: 09/12/2008
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0044	A. BUILDING _____ B. WING _____	09/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CMS	5610 FIRST STREET NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This licensure survey was conducted from September 3 2008 through September 4, 2008. Four male clients with varying degrees of disabilities reside in this facility. Two of the four clients were randomly selected for the sample. The findings of the survey were based on observations at the group home and two day programs, interviews with management and direct care staff in the residence and the review of the administrative records including the facility's incident management system.	R 000	Received 9/29/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of records, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. The findings include: Review of the personnel records on 9/5/08 at 1:30 PM revealed that the GHMRP failed to provide evidence that ensured criminal background checks were on file for one direct	R 125	The Director of Human Resources will ensure that criminal background checks are completed per regulations.	10/21/08

Health Regulation Administration

Marsha S. Thompson
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Director of Disability Svcs
TITLE

9/29/08
(X6) DATE

STATE FORM 6899 XFFF11 If continuation sheet 1 of 2

PRINTED: 09/12/2008
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CMS	5610 FIRST STREET NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 125	Continued From page 1 care staff (#1 and the Qualified Mental Retardation Professional.	R 125		